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	15G226	A. BUILDING 00 B. WING	01/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCCAZIO INC	1503 WASHINGTON ST NEW CASTLE, IN 47362

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W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: December 10, 11, 12, 13, 14, 17, 21, 27, 2012, January 7, and 8, 2013. Provider Number: 15G226 Facility Number: 000750 AIM Number: 100243210 Surveyors: Susan Eakright, Medical Surveyor III/QMRP/Team Leader Vickie Kolb, RN/BSN/Public Health Nurse Surveyor III These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed January 15, 2013 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to allow clients to have the right to access the locked handsoap and furnace closet in the group home. Findings include: During the12/10/12 observation period between 4pm until 6:20pm at the group home, clients #1, #2, #3, #4, #5, #6, #7, and #8's group home closet on the back hallway was locked and no handsoap was observed available for use in two of two bathrooms and kitchen areas of the group home. At 4:10pm, Direct Care Staff (DCS) #6 unlocked the laundry room and gave client #2 handsoap from a locked closet. At 5pm, DCS #6 unlocked the locked closet to show the furnace and hot water heater inside the locked closet. At 5pm, DCS #6 indicated client #5 had a history of flushing handsoap down the sink and indicated the staff gave out hand	W0125	**W 125 Protection of Client Rights** The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. **1. What corrective action will be accomplished?** · Clients #1, #2, #3, #4, #5, #6, #7, and #8 will be put on programming to learn how to handle hazardous materials correctly. · HRC approval will be obtained to have the hazardous materials and the furnace room locked until the Clients are able to show that they can use hazardous materials appropriately and access the furnace room	02/07/2013

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	soap for client use. On 12/10/12 at 5:35pm, the QDDP (Qualified Developmental Disabilities Professional) stated "the closet was always kept locked. Clients do not have keys for the lock and no one (clients #1, #2, #3, #4, #5, #6, #7, and #8) did not" have a documented reason for the restriction of the locked closet. At 5:35pm, the QDDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have an assessment available for review for the locked closets. At 5:45pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 indicated they did not have keys for the locked closets. Client #1's record was reviewed on 12/12/12 at 8:45 AM. Client #1's 12/7/11 and 12/6/12 ISP (Individual Support Plan) and 12/6/12 Behavior Support Plan (BSP) did not indicate client #1 had been assessed in regard to the need to lock handsoap, furnace, and the group home closets. Client #2's record was reviewed on 12/12/12 at 9:35 AM. Client #2's 1/4/12 ISP did not indicate client #2 had been assessed in regard to the need to lock handsoap, furnace, and the group home closets.		without concern. · Clients #1, #2, #3, #4, #5, #6, #7 and #8 will be put on programming to understand the need for the furnace room and the dangers within the room. · Clients #1, #2, #3, #4, #5, #6, #7 and #8 IPOP assessments will be updated to reflect their abilities to handle hazardous materials and the access the furnace room. · Staff will be trained on the Clients abilities to access the hazardous materials and the furnace room during their team meeting on 2-1-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The IPOP assessments for all of the residents will be reviewed and updated as their needs change. · Staff will be trained on the Clients abilities to access the hazardous materials and the furnace room during their team	

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			meeting on 2-1-13. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The IPOP assessments for all of the residents will be reviewed and updated as their needs change. · Staff will be trained on the Clients abilities to access the hazardous materials and the furnace room during their team meeting on 2-1-13. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a regular basis daily when in the home. · The Program Specialist will monitor as she completes her audits. **1.What is the date by which the systemic changes will be completed?**	

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			· February 7 th , 2013	

Client #3's record was reviewed on 12/12/12 at 1 PM. The client's record indicated no evidence for the need to lock the door to the furnace and handsoap in the home.

Client #4's record was reviewed on 12/12/12 at 4 PM. The client's record indicated no evidence for the need to lock the door to the furnace and handsoap in the home.

Interview with the QDDP on 12/13/12 at 11:25 AM, and on 12/14/12 at 10:35 AM, indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's handsoap and furnace closet were locked at the group home. The QDDP indicated clients do not use the chemicals correctly. The QDDP indicated the agency had not assessed clients #1, #2, #3, #4, #5, #6, #7, and #8 in regard to locking handsoap and the closets at the group home.

9-3-2(a)

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W0242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4), the facility failed to ensure the clients' ISPs (Individual Support Plans) included the clients' identified training objectives in regards to bathing, dressing and toothbrushing. Findings include: Client #1's record was reviewed on 12/12/12 at 8:45 AM. Client #1's 12/6/12 ISP (Individual Support Plan) indicated she required staff assistance with her personal care and no dressing objective. Client #1's ISP did not indicate a toothbrushing objective. Client #1's 2012 ICAP (Individual Comprehensive Assessment Profile) indicated she required staff assistance to complete dressing. Client #1's 8/10/12 Dental assessment indicated client #1 "required anesthesia yearly" to complete dental cleaning and recommended client #1 to	W0242	**W 242 Individual Program Plan** The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. **1. What corrective action will be accomplished?** · Programming will be implemented for Client #1 on tooth brushing and dressing. · Programming will be implemented for Client #2 on tooth brushing.	02/07/2013

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	brush teeth "three times daily." Client #2's record was reviewed on 12/12/12 at 9:35 AM. Client #2's 10/30/12 Dental assessment indicated client #2 "required" anesthesia to complete yearly dental cleaning. Client #2's 1/4/12 ISP did not include a toothbrushing objective. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated client #1's ISP did not include training objectives to assist client #1 with bathing, dressing, and oral hygiene. The RC indicated client #2's ISP did not include a training objective to teach client #2 oral hygiene. Client #3's record was reviewed on 12/12/12 at 1 PM. The client's ISP dated 3/29/12 indicated client #3 required staff assistance with most of her self care tasks. Client #3's ICAP (Individual Comprehensive Assessment Profile) of 9/10/12 indicated client #3 "never or rarely" independently dressed herself or washed her hair. Client #3's Updated IPPO (Individual Plan of Protective Oversight) dated 3/27/12 indicated client #3 requires "some verbal and some total assistance while conducting personal hygiene." The IPPO indicated client #3 required		· Programming will be implemented for Client #3 on dressing, bathing, and tooth brushing. · Programming will be implemented for Client #4 on dressing, bathing, hair washing, and oral hygiene. · The ISP's for Clients #1, #2, #3, #4 will be updated to include the above mentioned objectives. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change. **3. What measures will be**	

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	"verbal and physical prompts" to bathe and wash her hair and "total assistance in choosing her clothing" as "she will not choose weather appropriate clothing and clothing may not match." The IPPO indicated client #3 "requires supervision and verbal prompts for all areas of oral hygiene." Client #3's ISP did not indicate any training objectives to assist the client with dressing, bathing and oral hygiene. Client #4's record was reviewed on 12/12/12 at 4 PM. The client's ICAP of 9/13/12 indicated client #4 "never or rarely" dressed herself completely and neatly, or washes and rinses her hair. Client #4's updated "IPPO - Residential Information" of 5/26/11 indicated client #4 "requires assistance and monitoring when bathing and brushing teeth for task completion." Client #4's updated "IPPO - General Information" indicated the staff were to monitor client #4's tooth brushing 3 times a day. Client #4's ISP of 5/17/12 did not indicate any training objectives to assist the client with dressing, bathing, hair washing, and oral hygiene. Interview with DCS (Direct Care Staff) #10 on 12/11/12 at 8 AM indicated clients #3 and #4 required assistance with dressing, bathing and oral hygiene. Interview with the RC (Residential		**put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · As the residents needs changed programming will be implemented. · The residents behavior plans will be reviewed and updated as their needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	Coordinator) on 12/12/12 at 2 PM indicated client #3's and #4's ISPs did not include any training objectives to assist the clients with bathing, dressing and oral hygiene. 9-3-4(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 4 of 4 sample clients (#1, #2, #3 and #4), and 1 additional client (#6), the facility failed to ensure the DCS (Direct Care Staff) implemented the clients' ISP (Individual Support Plan) training objectives and provided formal and informal medication training when opportunity existed. Findings include: During observations at the group home on 12/11/12 between 6:20 AM and 7:30 AM the following was observed: 1. DCS #10 was observed preparing and giving client #1 Grifulvin V Tab (an anti-fungal medication), Zoloft (an antidepressant), Topiramate (an anti seizure medication), Tri Sprintec (for birth control) and 2 nasal sprays. DCS #10 did not offer client #1 any medication training while giving client #1 her medications.	W0249	**W 249 Individual Program Plan** As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. **1. What corrective action will be accomplished?** · Staff will be retrained on the importance of ensuring active treatment at all times, especially during the med pass during their staff meeting on 2-1-13. · A medication practicum will be done with Staff #6 and #10 by 2-7-13.	02/07/2013

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	2. DCS #10 was observed preparing and giving client #2 Calcium Carbonate (a dietary supplement), Cymbalta (for depression), Neurontin (for seizures) and Femara (used to treat breast cancer). DCS #10 did not offer client #2 any medication training while giving client #2 her medications. 3. DCS #10 was observed preparing and giving client #3 Asacol (for bowel problems), Levonest (for birth control), Claritin (for allergies), Nephro Cap (a dietary supplement) and Actigall (to decrease cholesterol). DCS #10 did not offer client #3 any medication training while giving client #3 her medications. 4. DCS #10 was observed preparing and giving client #4 Calcium Carbonate, Lamictal (given as a mood stabilizer) and Prilosec (for heartburn). DCS #10 did not offer client #4 any medication training while giving client #4 her medications.		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Random medication practicums will be completed with staff to ensure that they are following the proper med pass procedures and providing opportunities for active treatment. · Staff will be retrained on the importance of ensuring active treatment at all times, especially during the med pass during their staff meeting on 2-1-13. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · Random medication practicums will be completed with staff to ensure that they are following the proper med pass procedures and providing	

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	During observations at the group home on 12/10/12 from 4:10pm until 4:30pm, DCS #6 completed medication administration for clients #2, #4, and #6. At 4:10pm, DCS #6 dispensed client #2's oral medications Neurontin (for seizures) and		opportunities for active treatment. · Staff will be retrained on the importance of ensuring active treatment at all times, especially during the med pass during their staff meeting on 2-1-13. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	Zyprexa (for behaviors) into a medication cup, and gave the medications for client #2 to consume. DCS #6 did not offer client #2 any medication training while giving client #2 her medications. At 4:12pm, DCS #6 was dispensing client #4's medications Acetaminophen for arthritis and Oyster Shell Calcium for a nutritional supplement into a medication cup, and gave the medications for client #4 to consume. Client #4 did not point at the medications. DCS #6 did not offer client #4 any medication training while giving client #4 her medications. At 4:25pm, Client #6 dispensed with DCS#6 her medication Gabapentin (Neurontin) for seizures into a medication cup, and client #6 consumed the medication. DCS #6 did not name the medication, its reason for use, or give medication training information to client #6 regarding the Neurontin. Client #1's record was reviewed on 12/12/12 at 8:45am. Client #1's 12/6/12 ISP (Individual Support Plan) indicated an objective to identify the reasons for her Tylenol medication. Client #2's record was reviewed on 12/12/12 at 9:35 AM. Client #2's 1/4/12 ISP indicated an objective to identify the reasons for Tylenol medication.			

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	Client #3's record was reviewed on 12/12/12 at 1 PM. Client #3's ISP (Individual Support Plan) of 3/29/12 indicated client #3 had a formal objective to prepare items needed for her medication pass. Client #4's record was reviewed on 12/12/12 at 4 PM. Client #4's ISP of 5/17/12 indicated client #4 had a formal objective to point to her PM (evening) medications in the medication cart. Client #6's medication record was reviewed on 12/14/12 at 11am. Client #6's (no month) 2012 ISP indicated an objective to prepare items for her medication administration. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated the staff were to offer all clients formal and informal medication training at every available opportunity. The RC indicated staff administering medications should follow the six rights of medication administration which included naming each medication, dosages, the reasons for their use, and side effects. 9-3-4(a)			

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W0290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. Based on record review and interview, for 3 of 4 sample clients (client #1, #3, and #4), the facility failed to prohibit the use of standing as needed orders for the use of physical restraints. Findings include: Client #1's record was reviewed on 12/12/12 at 8:45am. Client #1's 4/26/12 physician's orders indicated a standing order for "physical restraints." The physician's orders indicated the order for restraints had been in place since 2011. Client #1's 12/6/12 BSP (Behavior Support Plan) did not indicate the use of physical restraints.	W0290	**W 290 Management of Inappropriate Client Behavior** Standing or as needed programs to control inappropriate behavior are not permitted. **1. What corrective action will be accomplished?** · The standing order for restraints has been removed from Client #1, #3, and #4's Medication Administration Record. · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting on 2-1-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The standing order for	02/07/2013

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			restraints has been removed from all of the Client's Medication Administration Records where restraint is not warranted in their behavior plan. · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting on 2-1-13. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The residents ISP's will be reviewed and updated as their needs change. · The standing order for restraints has been removed from all of the Client's Medication Administration Records where restraint is not warranted in their behavior plan. · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting on 2-1-13. **4. How will the corrective**	

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	Client #3's record was reviewed on 12/12/12 at 1 PM. The client's physician's orders dated 3/2012 through 12/2012 indicated a standing order for "physical restraints." The physician's orders indicated the order for restraints had been in place since 3/7/2011. The client's record did not indicate any targeted behaviors or a BSP (Behavior Support Plan). The client's Behavior Clinician Report dated 7/19/2012 indicated client #3 has had no reported behaviors and is not on any psychotropic medications. The report indicated client #3 did not need a BSP. Client #4's record was reviewed on		**action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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	12/12/12 at 4 PM. The client's physician's orders dated 3/2012 through 12/2012 indicated a standing order for "physical restraints." The physician's orders indicated the order for restraints had been in place since 3/7/2011. The client's BSP of 5/17/12 did not include the use of physical restraints. Interview with DCS (Direct Care Staff) #10 on 12/11/12 at 7:30 AM indicated no clients living in the group home required physical restraints due to behaviors. Interview with the RC (Residential Coordinator) on 12/12/12 at 4:30 PM indicated clients #1, #3, and #4 had standing orders for a physical restraint called "Handle with Care" to use if and when the clients might need to be restrained. The RC indicated clients #1, #3, and #4 had no history for the need of restraint. The RC stated the order was in place "just in case the staff would have to restrain" clients #1, #3, or #4. 9-3-5(a)			

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W0369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 2 of 43 medications observed being administered, the facility failed to ensure all medications were administered without error to client #4. Findings include: During observation at the group home on 12/10/12 at 4:12pm, DCS (Direct Care Staff) #6 administered client #4's medication from a medication blister package which indicated "ASA (Acetaminophen) 325mg (milligrams) every 8 hrs (hours)" for Arthritis. At 4:20pm, client #4's 12/2012 MAR (Medication Administration Record) was reviewed and indicated "ASA (Acetaminophen) 325mg every 6 hrs." During observations at the group home on 12/11/12 between 5:45 AM and 7:50 AM, client #4 was observed eating her breakfast at 6 AM. At 7:30 AM, staff #10 was observed giving client #4 Prilosec (given for indigestion) 20 milligrams. Review of client #4's medication pill packs indicated:	W0369	**W 369 Drug Administration** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. **1. What corrective action will be accomplished?** · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 2-1-13. · A medication practicum will be done with Staff #6 and #10 by 2-7-13. · Client #4's ASA medication order will be reviewed by the nurse. The MAR and medication label will be updated to ensure that it matches the physician's order. · Client #4's Prilosec will be retimed to allow it to be given before she eats breakfast.	02/07/2013

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	- Client #4 was to be given Prilosec 20 milligrams before food or a meal but not before 7:30 AM. - Client #4 was to be given ASA (Aspirin) 650 milligrams every 8 hours. Review of client #4's MAR (Medication Administration Record) for December 2012 at 7:35 AM indicated: - Client #4 was to be given Prilosec before food or a meal but not before 7:30 AM. - Client #4 was to get ASA 650 milligrams every 6 hours for Arthritis. Interview with DCS (Direct Care Staff) #10 on 12/11/12 at 7:40 AM indicated she had not noticed the special instructions on the MAR or on the pill pack for client #4 to be given her Prilosec before food or a meal but not before 7:30 AM. DCS #10 stated client #4 routinely eats her breakfast around 6 AM and the Prilosec had "always" been given after the client ate her breakfast. DCS #10 stated the nurse should have been notified of the discrepancy, but "Apparently no one caught it." Interview with the facility nurse on 12/13/12 at 9:30 AM indicated all medications were to be given as the physician had prescribed and as directed on the MAR. The facility nurse indicated		**2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Random medication practicums will be completed with staff to ensure that they are following the proper med pass procedures and the prescribed doctor's orders. · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 2-1-13. · The MAR's and medication labels will be reviewed by the IDT to ensure that the physician orders are being followed and everything matches. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Random medication practicums will be completed with	

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	the DCS were to triple check the medication with the physician's orders, the MAR and the pill pack to ensure all three match. The facility nurse indicated the DCS should have notified nursing of the discrepancy of not giving client #4 the Prilosec until 7:30 AM but prior to eating, and of the discrepancy in client #4's order for the ASA. Client #4's ASA physician's order indicated the medication was, to be taken every 6 hours. 9-3-6(a)		staff to ensure that they are following the proper med pass procedures and the prescribed doctor's orders. · Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 2-1-13. · The MAR's and medication labels will be reviewed by the IDT to ensure that the physician orders are being followed and everything matches. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, record review and interview the facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit for 4 of 4 sampled clients (client #1, #2, #3 and #4), and 4 additional clients (client #5, #6, #7 and #8), who could not adjust water temperatures. Findings include: On 12/10/12 from 4pm until 6:20pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home. During the observation period clients were observed to independently turn on and off the water in the kitchen, bathrooms, and laundry room. During observations at the group home on 12/11/12 between 5:45 AM and 8 AM, the water was observed to be too hot to keep this surveyor's hands in it for routine hand washing. Steam was observed rising from the sink. The water temperature was taken on 12/11/12 at 7:50 AM in the main bathroom in the group home and was	W0426	**W 426 Client Bathrooms** The facility must, in areas of the facility where clients who have not been trained to regulate the water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. **1. What corrective action will be accomplished?** · The water temperature in the home has been adjusted back to 110 degrees Fahrenheit. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on	02/07/2013

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	found to be 120 degrees Fahrenheit. Client #1's record was reviewed on 12/12/12 at 8:45am. Client #1's record did not indicate client #1 could adjust the water temperature at the group home. Client #2's record was reviewed on 12/12/12 at 9:35am. Client #2's record did not indicate client #2 could adjust the water temperature at the group home. Client #3's record was reviewed on 12/12/12 at 1 PM. The client's record did not indicate client #3 could adjust the water temperature within the group home. Client #4's record was reviewed on 12/12/12 at 4 PM. The client's record did not indicate client #4 could adjust the water temperature within the group home. Interview with DCS (Direct Care Staff) #10 and the RC (Residential Coordinator) on 12/11/12 at 8 AM indicated the water in the group home was not supposed to be above 110 degrees Fahrenheit. The RC indicated she would have to call someone to look at the water heater. Interview with the RC on 12/12/12 at 11am, indicated no documentation and no assessments were available for review to determine if clients #1, #2, #3, #4, #5, #6,		2-1-13. · Water temperature assessments will be completed with Client #1, #2, #3, #4, #5, #6, #7, and #8. · The IPOP assessments will be updated to reflect Client's #1, #2, #3, #4, #5, #6, #7, and #8's abilities to regulate water temperatures. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on 2-1-13. · The IPOP assessments	

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	#7, and #8 were capable of mixing hot water to a safe temperature when it exceeded 110 degrees Fahrenheit. 9-3-7(a)		and water temperature assessments will be reviewed and updated as the resident's needs change. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting on 2-1-13. · The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?**	

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			· The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. · The Maintenance Director will also monitor as he completes his checks. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8) who resided in the group home, to ensure evacuation drills were conducted at least quarterly for the day shift (7 AM - 3 PM) for the first quarter (January, February and March) and the second quarter (April, May and June) of 2012, and for the night shift (11 PM - 7 AM) for the third quarter (July, August and September) of 2012. Findings include: The facility's evacuation drills were reviewed on 12/10/12 at 3 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first and the second quarters of 2012 for the day shift and for the third quarter of 2012 for the night shift. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first and the second quarters of 2012 for the day shift and for	W0440	**W 440 Evacuation Drills** The facility must hold evacuation drills at least quarterly for each shift of personnel. **1. What corrective action will be accomplished?** · A day shift (7am-3pm) and night shift (11pm-7am) drill will be run by 2-7-13. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 2-1-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the	02/07/2013

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	the third quarter of 2012 for the night shift. 9-3-7(a)		same deficient practice. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 2-1-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 2-1-13. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a	

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			daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	

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W0460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the DCS (Direct Care Staff) followed the facility menu to ensure the clients received a nutritious meal. Findings include: During observations at the group home on 12/11/12 between 5:45 AM and 6:30 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their breakfast. The clients were observed eating cereal (cold and hot), toast, milk and juice. The clients did not eat peanut butter or cottage cheese. The Direct Care Staff did not offer the clients peanut butter or cottage cheese or a substitute for the peanut butter and cottage cheese that was on the menu. The facility Fall/Winter menus dated 10/7/09 were reviewed on 12/11/12 at 6:15 AM. --The menu labeled Regular Adult indicated the clients were to have 3/4 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 2 slices of whole wheat toast, 1 teaspoon of margarine, 1	W0460	**W 460 Food and Nutrition** Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets. **1. What corrective action will be accomplished?** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 2-1-13. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the	02/07/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	teaspoon of low sugar jelly, 2 tablespoons of peanut butter and 1 cup of skim or 1/2% milk. --The menu labeled Low Fat, Low Cholesterol, No Concentrated Sweets indicated the clients were to have 3/4 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 2 slices of whole wheat toast, 1 teaspoon of margarine, 1 teaspoon of low sugar jelly, 2 tablespoons of peanut butter and 1 cup of skim or 1/2% milk. --The menu labeled 1800 Kcal (calories) indicated the clients were to have 1/2 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 1/2 slice of whole wheat toast, 1 teaspoon of margarine, 1 teaspoon of low sugar jelly, 1 tablespoon of peanut butter and 1 cup of skim or 1/2% milk. --The menu labeled 1500 Kcal (calories) indicated the clients were to have 1/2 cup of orange juice, 3/4 cup of whole grain cereal cooked or dry, 1/2 slice of whole wheat toast, 1 teaspoon of margarine, 1 teaspoon of low sugar jelly, 1 tablespoon of peanut butter and 1 cup of skim or 1/2% milk. --The menu labeled Mechanical Soft indicated the clients were to have 3/4 cup of orange juice, 1 and 1/2 cup of whole grain cereal cooked or soaked until soft, 1 slice of whole wheat toast moistened and cut into 1/4 to 1/2 inch pieces, 1 teaspoon		potential to be affected by the same deficient practice. · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting on 2-1-13. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Regular meal observations will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G226	A. BUILDING 00 B. WING	01/08/2013

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	of margarine, 1 teaspoon of low sugar jelly, 1/4 cup of low fat cottage cheese and 1 cup of skim or 1/2% milk. Interview with DCS #10 on 12/11/12 at 8 AM indicated the menus previously reviewed were the menus the staff were to follow in preparing clients #1, #2, #3, #4, #5, #6, #7 and #8's meals. DCS #10 indicated the staff were to follow the facility menus and to offer all of the food on the menu. DCS #10 stated, "That's my fault, I didn't offer the peanut butter. We have a couple of ladies that have choking issues and I just thought it wouldn't be a good idea for them to have peanut butter." DCS #10 indicated she should have offered the clients a substitute protein, but she had not thought about it at the time breakfast was being prepared. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated the DCS were to offer all of the items on the menu or to provide a like substitute for the food not offered. 9-3-8(a)		of following the menu at their staff meeting on 2-1-13. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The RC will monitor on a daily basis when they are in the home. · The Program Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** February 7 th , 2013	